

Kuji Pediatric Clinic Pre-visit Questionnaire

Name : _____ Age : _____ Male / Female

What is the primary reason for this visit? _____

Temp _____ °C	weight _____ kg
fever : No • Yes	since when: (_____)
cough : No • Yes	runny nose : No • Yes
diarrhea : No • Yes	vomitting : No • Yes

Any medical condition under treatment? No • Yes
Describe : _____

Are you(your child) on any medications? No • Yes
Describe : _____

Do you(your child) have history of drug allergy? No • Yes
(what medication, what happens?) _____

Type of medicine preferred: syrup/suspension • powder/dry syrup • tablet

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